HEALTH PLAN DESCRIPTION FORM –PPO-H		
	PPO-H (HSA eligible)	
	In-network	**Out-of-network**
Important Note: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will pay.		
Part A: Type of Coverage		
1. Type of Plan	Preferred Provider Organization	
2. Out-of-Network Care Covered?[1]	Yes, but patient pays more for out-of-network care.	
3. Areas of Colorado where Plan is Available	Plan is available throughout Colorado	
Part B: Summary of Benefits		
4. Annual Deductible **a) Individual** **b) Family**	 $1,000 $2,000 (family deductible must be satisfied before benefits are paid for any individual family member)	 $2,000 $4,000 (family deductible must be satisfied before benefits are paid for any individual family member)
5. Out-of-Pocket maximum per calendar year[2] **a) Individual** **b) Family**	 $5,000 $10,000 The in-network out-of-pocket maximum is not applied towards the out-of-network out-of-pocket maximum.	 $10,000 $20,000 The out-of-network out-of-pocket maximum is not applied towards the in-network out-of-pocket maximum.
6. Lifetime or Benefit Maximum Paid by the Plan for All Care	Not applicable	
7A.Covered Providers	Great-West Healthcare Preferred Provider Network; Pharmacy Services provided by Express Scripts by arrangement with Great-West Healthcare	All providers licensed or certified to provide covered benefits.
7B.With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable
8. Routine Medical Office Visits	85% after deductible	65% after deductible
9. Preventive **a) Children's services** **b) Adults' services**	 85% not subject to deductible 85% not subject to deductible	 65% not subject to deductible 65% not subject to deductible
10. Maternity **a) Prenatal care** **b) Delivery & Inpatient well baby care**	 85% after deductible 85% after deductible	 65% after deductible 65% after deductible
11. Prescription Drugs Level of coverage and restrictions on prescriptions a) **Retail** - Generic - Brand Name - Non-formulary b) **Mail Order** - Generic - Brand Name - Non-formulary c) **Self-admin. injectibles disp. thru pharmacy** d) **Injectibles admin. in**	 85% after deductible (annual deductible – see #4 above) 85% after deductible (annual deductible – see #4 above) – No financial benefit to purchasing via mail order. 85% after deductible 70% after deductible (annual deductible –	 65% after deductible (annual deductible – see #4 above) Not covered (no mail order out-of-network benefit) 65% after deductible (annual deductible – see #4 above) 70% after deductible (annual deductible – see #4

HEALTH PLAN DESCRIPTION FORM –PPO-H		
	PPO-H (HSA eligible)	
	In-network	**Out-of-network**
office or OP facility	see #4 above)	above)
12. Inpatient Hospital	85% after deductible	65% after deductible
13. Outpatient/Ambulatory Surgery	85% after deductible	65% after deductible
14.		
a) **Laboratory**	85% after deductible	65% after deductible
b) **X-ray**	85% after deductible	65% after deductible
c) **MRI/PET/CAT scans**	85% after deductible	65% after deductible
15. Emergency Care[3]	85%	65%
16. Ambulance		
a) **Ground**	100% after deductible, maximum benefit $350	
b) **Air**	100% after deductible, maximum benefit $2,500	
17. Urgent		
a) **Inpatient**	85% after deductible	65% after deductible
b) **Outpatient**	85% after deductible	65% after deductible
18. Biologically Based Mental Illness[4] Care	85% after deductible	65% after deductible
19. Other Mental Health Care		
a) **Inpatient care**	85% after deductible, 45 full/90 partial days per year. Number of days applies to both in and out-of-network, combined with Alcohol & Substance Abuse	65% after deductible, 45 full/90 partial days per year. Number of days applies to both in and out-of-network, combined with Alcohol & Substance Abuse
b) **Outpatient care**	85% after deductible, 30 visits yr, Number of visits applies to both in and out-of-network, combined with Alcohol & Substance Abuse	65% after deductible, 30 visits yr, Number of visits applies to both in and out-of-network, combined with Alcohol & Substance Abuse
20. Alcohol & Substance Abuse		
a) **Inpatient Rehab**	85% after deductible, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health	65% after deductible, 45 full /90 partial days per year / 60 days lifetime, combined with other mental health
b) **Outpatient**	85% after deductible, 30 visits per year, combined with other mental health, 60 visits lifetime. Number of visits applies to both in and out-of-network.	65% after deductible, 30 visits per year, combined with other mental health, 60 visits lifetime. Number of visits applies to both in and out-of-network.
21. Physical, Occupational & Speech Therapy		
a) **Inpatient**	85% after deductible	65% after deductible
b) **Outpatient**	85%, 20 visits / year for each therapy Number of visits applies to both in and out-of-network.	65%, 20 visits / year for each therapy Number of visits applies to both in and out-of-network.
22. Durable Medical Equipment		
a) **Inpatient**	85% after deductible	65% after deductible
b) **Outpatient including supp.**	85%, maximum $3,000/year, combined with oxygen. Maximum applies to both in and out-of-network.	65%, maximum $3,000/year, combined with oxygen. Maximum applies to both in and out-of-network.
23. Oxygen		
a) **Inpatient**	Included in hospital	Included in hospital
b) **Outpatient**	Included in DME	Included in DME
24. Organ Transplants	85% after deductible	65% after deductible
25. Home Health Care	85%, 60 visits / year. Number of visits applies to both in and out-of-network.	65%, 60 visits / year. Number of visits applies to both in and out-of-network.

HEALTH PLAN DESCRIPTION FORM –PPO-H		
	PPO-H (HSA eligible)	
	In-network	**Out-of-network**
26. Hospice a) **Inpatient** b) **Outpatient**	85%, 30 days / year. Number of days applies to both in and out-of-network. 85%, 91 days / year. Number of days applies to both in and out-of-network.	65%, 30 days / year. Number of days applies to both in and out-of-network. 65%, 91 days / year. Number of days applies to both in and out-of-network.
27. Skilled Nursing Facility Care	Not covered	Not covered
28. Dental Care	Not covered	Not covered
29. Vision Care	85% after deductible. No benefit for hardware.	65% after deductible. No benefit for hardware.
30. Chiropractic Care	85% after deductible, maximum benefit $750/year. Maximum applies to both in and out-of-network.	65% after deductible, maximum benefit $750/year. Maximum applies to both in and out-of-network.
31. Significant Additional Covered Services	Hearing aid:85% after deductible, limited to $500 every 3- years. Limit applies to both in and out-of-network. Infertility: 85% after deductible , maximum benefit $2,500/year. Limit applies to both in and out-of-network.	Hearing aid:65% after deductible, limited to $500 every 3- years. Limit applies to both in and out-of-network. Infertility: 65% after deductible, maximum benefit $2,500/year. Limit applies to both in and out-of-network.
Part C: Limitations and Exclusions		
32. Period During which Pre-Existing Conditions are not Covered[5]	Not applicable. Plan does not impose limitation periods for pre-existing conditions	
33. Exclusionary Riders. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	
34. How Does the Policy Define a "Pre-existing Condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.	
35. What Treatments & Conditions are Excluded Under this Policy?	See summary plan description for list of exclusions.	
Part D: Using the Plan		
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Great-West Healthcare
39. What is the main customer service number?	1-888-ST8-OFCO (1-888-788-6326)	
40. Whom do I write/call if I have a complaint or want to file a grievance?[6]	Great-West Healthcare P.O. Box 22222 Fort Scott, KS 66701 (1-800-663-8081)	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		

HEALTH PLAN DESCRIPTION FORM –PPO-H		
	PPO-H (HSA eligible)	
	In-network	**Out-of-network**
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Number 179528 Self-funded large group.	
43. Does the plan have a binding arbitration clause?	No	
Part E: Cost		
44. What is the cost of this plan? a) **Employee Only** b) **Employee + Child(ren)** c) **Employee + Spouse** d) **Family**	Final rates will be made available via the Benefits newsletter, *HealthLine*, and on the Benefits website www.colorado.gov/dpa/dhr.	

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

[1]"Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2]Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copay, depending on the contract for that plan.

[3]"Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[4]"Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[5]Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[6]Grievances. The formal grievance process (not to be confused with appeals) is in development.